STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185268	A. BUILDING _____ B. WING _____	C 07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification/Abbreviated Survey was conducted 07/27/10 through 07/30/10. A Life Safety Code Survey was conducted 07/29/10. Deficiencies were cited with the highest scope and severity of an "F". ARO KY00015092 was substantiated with deficiencies. ARO KY 00014245, ARO KY 00014630 and ARO KY00014574 were substantiated with no deficiencies. ARO KY00014676, KY 00014411, and, ARO KY 00014677 were unsubstantiated.	F 000	**Plan of Correction** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157		

RECEIVED
AUG 30 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beverly M. Mattingly | TITLE: Administrator | (X6) DATE: 8/25/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to immediately inform the physician of a change in the residents' condition for two (2) of nineteen (19) sampled residents (Resident #12 and #14). The findings include 1. Review of Resident #12's medical record revealed diagnoses which included Alzheimer's Disease, Senile Dementia, and Constipation. Review of the June 2010 Physician's Orders, revealed orders for Senna S two tablets every night for constipation, and Miralax seventeen (17) grams with water every morning for constipation. Further review of the Physician's Orders revealed no "as needed" (prn) orders for a laxative. Review of Resident #12's Bowl Movement (BM) Record revealed no documented evidence of the resident having a bowel movement for six (6) days, 06/11/10 to 06/17/10. Further review of the BM Record revealed no documented evidence of the resident having a bowel movement for seven (7) days, 06/17/10 to 06/24/10. Continued review of the BM Record revealed no documented evidence the resident had a bowel movement for seven (7) days from 06/28/10 to 07/05/10.	F 157	F157 1. A prn laxative order was obtained for Resident #12 on 7/30/10 and Resident #14 on 7/28/10. 2. Nurses will monitor the BM alert report each shift. If a resident has not had a BM for 3 days a prn laxative will be given. If a prn laxative has not been ordered the nurse will notify the physician and request a prn laxative order. 3. CNAs will be re-educated by the Staff Development Coordinator or designee on the importance of documenting BM's in the hand-held device each shift. Nurses will be re-educated by the Staff Development Coordinator or designee regarding monitoring resident BM's each shift by checking the BM computer alert report. Nursing staff will be in-serviced by the Staff Development Coordinator or designee on "trouble-shooting" regarding the hand-held device. Nurses will be re-educated by the Staff Development Coordinator or designee to administer and document "prn" laxatives given per physician orders when a resident has not had a BM for 3 days. Nurses will be re-educated by the Staff Development Coordinator to contact the physician if a resident has not had a BM for 3 days and request a "prn" laxative order.	9/13/10

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F 157	Continued From page 2 Review of the June 2010 Nurse's Notes and Physician's Orders revealed no documented evidence the Physician was notified related to the resident's lack of a bowel movement. Interview on 07/30/10 at 7:35 AM with Licensed Practical Nurse #4, who was assigned to Resident #12, revealed the resident had no as needed (prn) laxatives ordered. She stated, she was unsure why the resident had gone greater than three (3) days without a bowel movement and she was unsure why the Physician had not been notified. 2. Review of Resident #14's medical record revealed the resident was admitted with diagnoses which included Dementia, Diabetes Mellitus, and Generalized Weakness. Review of the June 2010 and July 2010 Physician's Orders revealed an order for Senna-S 2 tablets every night. Review of the Bowel Movement (BM) Record revealed no documented evidence of a BM for six (6) days, from 06/03/10 until 06/09/10; for five (5) days, from 06/09/10 until 06/14/10; and no documented evidence of a BM for eight (8) days, from 06/14/10 until 06/22/10. Further review revealed no documented evidence of a BM for seventeen (17) days, from 06/24/10 through 07/11/10, no documented evidence of a BM for six (6) days, 07/11/10 through 07/17/10 and no documented evidence of a BM for ten (10) days, from 07/17/10 through 07/27/10. Review of the Nurse's Notes revealed no documented evidence the Physician was notified of the resident's lack of bowel movements until	F 157	CNAs will report to their charge nurse at the end of each shift to ensure required resident BM documentation has been entered into the hand held device. Nurses will monitor the BM alert report each shift. If a resident has not had a BM in 3 days a prn laxative will be administered or the MD will be notified of the condition if there is no prn laxative order. The DNS or designee will monitor the BM alert report daily. If a resident has not had a BM for 3 days the DNS or designee will ensure a prn laxative was administered or the MD was notified. 9/13/10. 4 The QA Nurse will perform a random audit each month on 10% of residents on each unit. The audit will include administration of prn laxatives and notification of the MD when applicable. This audit will be performed monthly for 6 months and findings reviewed in monthly QA meetings for further evaluation and recommendations. 9/13/10.	9/13/10 9/13/10

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F 157	Continued From page 3 07/28/10. Review of the Physician's Orders revealed the Physician ordered Milk of Magnesia (medication used for constipation) 30 milliliters (mls) every day as needed on 07/28/10. Interview on 07/30/10 at 8:35 AM with Licensed Practical Nurse (LPN) #2/ AB Unit Manager, revealed nurses were required to check bowel movements in the computer every shift. She stated, the nurses would then administer a laxative if the resident went three (3) days without a bowel movement, unless a laxative was contraindicated. Further interview revealed if there was no Physician's Order for a laxative, the nurses were required to call the Physician to obtain an order. She further stated, the Certified Nursing Assistants (CNAs) were to document all bowel movements each shift.	F 157	F281 1. Residents 3, 10, and 15 will be given prn laxatives if they go 3 days without having a BM. 2. Nurses will monitor the BM alert report each shift. If a resident has not had a BM for 3 days they will administer the prn laxative per MD order. 3. Nurses will be in-serviced by the Staff Development Coordinator or designee to check the BM alert report to ensure resident's BM's are documented by the CNAs. If the report shows the resident has not had a BM for 3 days the nurse will follow the physician's order and administer the prn laxative. 9/13/10.	9/13/10
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Physician's orders were followed for three (3) of nineteen (19) sampled residents (Residents #3, 15 and 10). These residents had Physicians Orders for prn (as needed) medications for constipation. However, there was no documented evidence laxatives were administered when the residents went greater than 3 (three) days without a bowel movement, as per facility protocol.	F 281	In addition, CNA's will report to their charge nurse at the end of each shift to ensure required resident BM documentation has been entered into the hand held device. The DNS or designee will also monitor the BM alert report daily x 4 months. Any resident that has not had a BM for 3 days will be investigated to ensure MD orders were followed when applicable. 9/13/10. 4. The QA nurse will perform a random audit each month on 10% of residents that have care plans to monitor BM's. The audit will address the monitoring of BM's and if the plan of care was followed. This audit will be performed monthly for 6 months and findings reviewed in the monthly QA meetings for further evaluation and recommendation. 9/13/10.	9/13/10

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F 281	Continued From page 4 The findings include: 1. Review of Resident #10's medical record revealed diagnoses which included Dementia, Alzheimer's, Anxiety, Hypertension, Depressive Disorder, Hyperlipidemia and Atherosclerosis. Review of the Minimum Data Set (MDS) Assessment dated May 05, 2010 revealed the facility assessed the resident as being moderately impaired in cognitive skills for daily decision making and as being incontinent of bowel and bladder. Review of the Comprehensive Plan of Care, dated 03/12/10 revealed Resident #10 had the potential for constipation related to the daily use of narcotic pain medications. Further review revealed interventions which included notifying the Physician and family if the resident had no bowel movement for three (3) days and medications as ordered. Review of the Bowel Movement (BM) Record revealed the resident did not have a documented bowel movement from 06/15/10 to 06/25/10, ten (10) days. Review of the Physician's Orders, dated 02/26/10 revealed orders for MOM (Milk of Magnesia) 30 cc PO (by mouth) everyday PRN (as needed) for constipation and "Fleets" enema one (1) rectally if no BM (bowel movement) for three (3) days for constipation. Interview on July 30, 2010 at 11:00 AM with the Director of Nursing revealed she felt the residents had not gone that long without having a bowel movement. She stated, she felt the Certified Nursing Assistants (CNA's) had not properly	F 281		

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F 281	Continued From page 5 documented the bowel movements. 2. Review of Resident #3's medical record revealed diagnoses which included Senile Dementia and Constipation. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/08/10 revealed the facility assessed the resident as moderately impaired in cognitive skills, as being unable to ambulate; requiring extensive assistance to transfer; and, as having incontinence of bowel and bladder. Review of the Physician's Orders dated 07/10 revealed orders for Miralax 17 Grams every night routinely and Senna S two tablets prn (as needed) for constipation. Review of the Bowel Record revealed there was no bowel movements recorded from 07/08/10 until 07/15/10 which was seven (7) days later. Review of the 07/10 Medication Administration Record (MAR) revealed there was no documented evidence the prn Senna S had been administered as ordered. Interview on 07/27/10 at 5:00 PM, 07/28/10 at 5:00 PM and 07/30/10 at 10:30 AM with Licensed Practical Nurse (LPN) #2/Unit D, Nurse Manager on the unit where Resident #3 resided, revealed it was the staff nurse's responsibility to monitor the bowel movements each shift and to administer a prn laxative as ordered if a resident went three (3) days without a bowel movement. She was unsure why the medication had not been administered as ordered. 3. Review of Resident # 15's medical record revealed the resident was admitted with	F 281		

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F 281	Continued From page 6 diagnoses which included depression, head injury, chronic back pain with spinal stenosis, chronic urinary tract infections and pernicious anemia. Review of the June and July orders revealed an order for Miralax seventeen (17) grams by mouth every two (2) to three (3) days as needed without a bowel movement. Review of the Bowel Movement records revealed there was no documented bowel movements for Resident #15 for the following dates: 06/09/10 through 06/13/10, 07/06/10 through 07/09/10 and 07/12/10 through 07/15/10. Review of Medication Administration Records for June and July revealed no documentation of Resident #15 having received the laxative per physician's orders. Interview with Registered Nurse #3 revealed it was the Certified Nursing Assistant's (CNA) responsibility to document whether or not the residents have bowel movements every shift and the nurses are to check the records at the beginning and end of each shift. She further indicates the facility had multiple inservices on the use of the hand held computerized data collectors used to document the bowel movements with the CNAs to educate them how to enter the information.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow the Comprehensive Plans of Care for three (3) of nineteen (19) sampled residents (Residents 4, 13 and 10). These residents had Care Plan interventions to monitor bowel movements; however, there was no evidence the bowel records were monitored. The findings include: 1. Review of Resident #4's medical record revealed diagnoses which included Dementia, Diverticulitis, Irritable Colon, and Constipation. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 06/24/10, and the Quarterly MDS Assessment dated 03/09/10 revealed the facility assessed the resident as being moderately impaired in cognitive skills for daily decision making, as being unable to ambulate, and as being totally incontinent of bowel and bladder. Review of the Resident Assessment Protocol Summary (RAPS), dated 06/23/10 revealed the resident was recently hospitalized with an ileus and/ or bowel obstruction. Review of the Comprehensive Plan of Care dated, 05/19/10 revealed the resident had an alteration in elimination related to routine pain medications. The goal stated the resident would have a bowel movement at least every two to three days. The interventions included encouraging fluids, and monitoring bowel	F 282	F282 1. The care plan to monitor BM's for residents #4, 10 and 13 will be reviewed with the Nursing staff by the Unit Coordinators or designee. Nurses will be in-serviced by the Staff Development Coordinator or designee on the importance of following the care plans on residents regarding monitoring BM's. 9/13/10. 2. All residents BM record will be monitored daily by the nurses each shift. Nurses will be in-serviced by the Staff Development Coordinator or designee to follow the plan of care when a resident does not have a BM for 3 days. 9/13/10. 3. Nurses will monitor BM's each shift on all residents. The nurse will follow the plan of care when applicable. The DNS or designee will monitor the BM alert report daily x 4 months. If a resident has not had a BM for 3 days there will be follow-up to ensure the plan of care was followed. 4. The QA nurse will perform a random audit each month on 10% of residents that have care plans to monitor BM's. The audit will address the monitoring of BM's and if the plan of care was followed. This audit will be performed monthly for 6 months and findings reviewed in the monthly QA meetings for further evaluation and recommendation. 9/13/10.	9/13/10 9/13/10 9/13/10 9/13/10

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F 282	Continued From page 8 movements every shift. Review of the Bowel Movement Record revealed the resident had a medium loose bowel movement on 05/22/10. Further review of the Record revealed the next recorded BM was on 05/26/10, four (4) days later, which was described as small and loose. Review of the May 2010 Physician's Orders revealed the resident was receiving Senna-S two tablets every night related to constipation while taking pain medications. The order was changed to Senna S one every night on 05/13/10. There were no orders noted for a prn (as needed) laxative. Review of the Nurse's Notes, dated 05/29/10 at 10:00 PM revealed the resident's abdomen was distended, the resident reported pain upon palpitation of the abdomen, and no bowel sounds were noted with the assessment. Further review of the Notes, revealed the Physician was notified and the resident was transferred to the hospital at 11:00 PM.. Review of the Hospital Discharge Summary dated 06/16/10 revealed the resident was admitted to the hospital on 05/30/10 with diagnoses which include Adynamic Ileus, and Severe Malnutrition with associated Hypokalemia, Hypocalcemia, and Hypothyroidism. The Summary further stated the resident was admitted with evidence of a fecal impaction and received a tap water enema, and Dulcolax Suppositories. Further review of the Summary revealed the resident received Total Parental Nutrition and slowly had the diet advanced. Review of the Gastroenterology consultation dated 05/30/10 revealed the	F 282		

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F 282	Continued From page 9 Abdominal CT Scan revealed a moderate amount of formed stool in the rectum, concern for impaction. Interview on 07/28/10 at 3:15 PM with Licensed Practical Nurse (LPN) #7 revealed she worked the AB unit in which Resident #4 resided in May 2010 and was familiar with the resident. She stated the Nurse Manager checked the computer daily and alerted the nurses if a resident had not had a BM in three days. The nurse would administer a laxative or call the Physician if the resident had no prn (as needed) laxative. She further stated the nurses did not routinely check the BMs on the unit, and depended on the Nurse Manager to check the computer. Interview on 07/28/10 at 3:20 PM with Registered Nurse (RN) #3 revealed she worked on the AB unit in which Resident #3 resided in May 2010. She stated, the nurses were to check the computer every shift to monitor for bowel movements and if the resident had no BM in two to three days, a prn laxative would need to be administered as ordered, or the Physician would need to be called for orders, RN #3 reviewed the BM Record for Resident #4 and stated the resident should have received an abdominal assessment on 05/25/10 to assess for the need of a laxative. She further stated the small loose BM on 05/26/10 could have indicated a problem with a possible "impaction" due to no regular bowel movements were recorded since 05/22/10. Interview on 07/28/10 at 3:30 PM and 07/30/10 at 11:15 AM with LPN #2, who was the Nurse Manager on the AB unit in which Resident #4 resided in May 2010, revealed the nurses on the unit were to check the computer each shift to	F 282		

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F 282	Continued From page 10 monitor for BMs. She further stated, if the residents had no BM in three days a laxative should be administered as ordered or the Physician should be notified to obtain an order for a prn (as needed) laxative. LPN #2 reviewed Resident #4's Bowel Record and stated the resident should have received a prn laxative on 05/25/10. She stated, since the resident had no prn (as needed) order for a laxative, the Physician should have been called to obtain an order for a laxative. LPN #2 stated she tried to check the computer at times to ensure the residents were having BM's at least every three days and leave a list of residents who required a laxative for the nurses; however, she did not do this routinely. She stated it was ultimately the nurses responsibility to review the bowel records and follow the bowel protocol. 2. Review of Resident #10's medical record revealed diagnoses which included Dementia, Alzheimer's, Atherosclerosis,Hypertension, Hyperlipidemia, Urinary/ Bowel Incontinence and Osteoarthritis. Review of the Minimum Data Set, dated 05/26/10 revealed the facility assessed the resident as being moderately impaired to make daily decisions and requiring supervision, requiring extensive assist of one person for transfers and as being frequently incontinent of bowel and bladder. Review of the Comprehensive Plan of Care dated 06/02/10 revealed this resident had the potential for constipation related to the daily use of narcotic pain medications. Interventions included; encouraging fluid intake, monitoring bowel sounds for hypoactivity, monitoring for abdominal distension, tenderness, or bloating, administering medications as ordered and notifying the	F 282		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11 Physician if the resident had no bowel movements for three (3) days. Review of the Bowel Movement Record revealed no documented evidence of bowel movements from 06/15/10 until 06/25/10. Review of the Physician's Orders dated 07/01/10, revealed orders for an enema to be administered if no bowel movement within three (3) days. Review of the Medication Administration Record (MAR), dated 07/01/10 revealed there was no documented evidence of the enema being administered as ordered. Interview on 07/28/10 at 4:15 PM with the Director of Nursing revealed the facility's bowel protocol was to administer the laxative or medication as ordered for constipation if the resident had not had a bowel movement in three days. 3. Review of the Comprehensive Care Plan, dated 07/21/10 for Resident #13 revealed bowel movements were to be recorded every shift and if there was no bowel movement after three days the nurse was to be notified. The resident was also noted to be incontinent of bowel and bladder and the intervention included briefs and toilet upon resident's request. Review of the Bowel Movement Record revealed no documentation of bowel movements from 07/17/10 through 7/21/10. Interview on 07/30/10 at 8:08 AM with Licensed Practical Nurse # 1 revealed the physician ordered laxative had not been given.	F 282		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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	185268	A. BUILDING _____ B. WING _____	C 07/30/2010

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F 309 SS=E	Continued From page 12 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for four (4) of nineteen (19) sampled residents (Resident #4, #3, #12, and #14). The facility failed to ensure each residents bowel movements were monitored in order to implement the bowel protocol. Resident #4 did not have a bowel movement for four days, from 05/22/10 until 05/26/10. The facility's failed to monitor this resident's bowel movents and ensure the bowel protocol was implemented. The resident was hospitalized on 05/30/10 with diagnoses which included Fecal Impaction. The findings include: 1. Review of Resident #4's medical record revealed diagnoses which included Dementia, Diverticulitis, Irritable Colon, Constipation, and Pain. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 06/24/10 revealed the facility assessed the resident as having both short and long term memory loss, as being unable to ambulate, and as being totally	F 309	F309 1. The facility will monitor the bowel movements of residents 3, 4, 12 and 14 to ensure that we implement the bowel protocol. 2. Nurses will be in-serviced by the Staff Development Coordinator or designee to monitor the BM alert report each shift on all residents and to follow the bowel protocol when applicable. 9/13/10. 3. CNAs will be re-educated by the Staff Development Coordinator or designee on the importance of documenting BM's in the hand-held device each shift. Nurses will be re-educated by the Staff Development Coordinator or designee regarding monitoring resident's BM's each shift by the BM computer alert report and to follow the bowel protocol when applicable. CNAs will report to their charge nurse at the end of each shift to ensure required resident BM documentation has been performed. Nurses will check the BM alert report on their residents each shift and follow the bowel protocol when applicable. The DNS or designee will monitor the BM alert report daily x 4 months. If a resident has not had a BM for 3 days there will be follow up to ensure the bowel protocol was followed. 9/13/10.	9/13/10 9/13/10

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F 309	Continued From page 13 Incontinent of bowel and bladder. Review of the Quarterly MDS Assessment dated 03/09/10 revealed the facility assessed the resident as having short term memory loss, as being unable to ambulate, and as being totally incontinent of bowel and bladder. Review of the Resident Assessment Protocol Summary (RAPS) dated 06/23/10 revealed the resident was recently hospitalized with a ileus and/ or bowel obstruction. Review of the Comprehensive Plan of Care dated 05/19/10 revealed the resident had an alteration in elimination related to routine pain medications with a goal for the resident to have a bowel movement at least every two to three days. The interventions included; encouraging fluids, and monitoring bowel movements every shift. Review of the May 2010 Physician's Orders revealed the resident was receiving Senna-S two tablets every night related to constipation while taking pain medications. The order was changed to Senna S one every night on 05/13/10. Continued review of the orders revealed the resident received Hydrocodone 5/500 milligrams one tablet every day for pain (Hydrocodone -analgesic narcotic with side effects including constipation). Review of the Bowel Movement (BM) Record revealed the resident had a medium loose bowel movement on 05/22/10. Further review of the Record revealed the next recorded BM was on 05/26/10 which was described as small and loose. Review of the Nurse's Notes, dated 05/29/10 at	F 309	4. The QA Nurse will perform a random audit each month on 10% of residents on each unit. The audits will focus on resident's BM's being monitored and if the bowel protocol was followed. This audit will be performed monthly for 6 months and findings reviewed in the monthly QA meetings for further evaluation and recommendations.	9/13/10

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F 309	Continued From page 14 10:00 PM revealed the resident's abdomen was distended and the resident "cried out and reported pain" upon palpitation of the abdomen. Further assessment revealed there were no bowel sounds noted. Continued review of the Notes, revealed the Physician was notified and the resident was transferred to the hospital at 11:00 PM. Review of the Hospital Discharge Summary, dated 06/16/10 revealed the resident was admitted to the hospital on 05/30/10 with diagnoses which included Adynamic Ileus, and Severe Malnutrition with associated Hypokalemia, Hypocalcemia, and Hypothyroidism. The Summary further stated the resident was admitted with evidence of fecal impaction and received a tap water enema, and Dulcolax Suppositories. Further review of the Summary revealed the resident received Total Parental Nutrition and slowly had the diet advanced. Review of the Gastroenterology consultation dated 05/30/10 revealed the Abdominal CT Scan revealed a moderate amount of formed stool in the rectum, concern for impaction. Interview on 07/28/10 at 3:15 PM with Licensed Practical Nurse (LPN) #7 revealed she worked the AB unit in which Resident #4 resided in 05/10 and was familiar with the resident. She stated the Nurse Manager checked the computer daily and alerted the nurses if a resident had not had a BM in three days. The nurse would administer a laxative or call the Physician if the resident had no prn (as needed) laxative. She further stated the nurses did not routinely check the BM's on the unit, and depended on the Nurse Manager to check the computer.	F 309		

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F 309	Continued From page 15 Interview on 07/28/10 at 3:20 PM with Registered Nurse (RN) #3 revealed she worked on the AB unit in which Resident #3 resided in 05/10. She stated, the nurses were to check the computer every shift to monitor for BM's. She further stated if the residents had no BM in two to three days, a prn laxative would need to be administered or the Physician would need to be called for orders. After reviewing the BM Record for Resident #4, she stated the resident should have received an abdominal assessment on 05/25/10 to assess for the need for a laxative. She further stated the small loose BM on 05/26/10 could have indicated a problem with a possible impaction, as no regular bowel movements had been recorded since 05/22/10. Interview on 07/28/10 at 3:30 PM and 07/30/10 at 11:15 AM with LPN #2, who was the Nurse Manager on the AB unit in which Resident #4 resided in 05/10, revealed the nurses on the unit were to check the computer each shift to monitor for BM's. She stated if the residents had no BM in three (3) days a laxative should be administered as ordered or the Physician should be notified to obtain an order for a prn (as needed) laxative. After reviewing Resident #4's Bowel Record, LPN #2 stated the resident should have received a prn laxative on 05/25/10. She further stated, if the resident had only a small loose bowel movement on 05/26/10, the resident should have had an abdominal assessment performed by the nurse. LPN #2 stated she tried to check the computer at times to ensure the residents were having BM's at least every three days and leave a list of residents who required a laxative for the nurses; however, she did not do this routinely. She stated it was ultimately the nurse's responsibility to review the bowel records.	F 309		

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F 309	Continued From page 16 2. Review of Resident #3's medical record revealed diagnoses which included Senile Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/08/10 revealed the facility assessed the resident as having both short and long term memory loss, as being unable to ambulate, requiring extensive assistance to transfer, and as having incontinence of bowel and bladder. Review of the Comprehensive Plan of Care, dated 07/14/10 revealed the resident was incontinent of bowel and bladder and was encouraged to toilet upon raising, before or after meals, and before bed and as needed. Review of the Physician's Orders dated 07/10 revealed orders for Miralax 17 Grams every night routinely and Senna S two tablets as needed for constipation. Review of the Bowel Record revealed there was no documented evidence of bowel movement from 07/08/10 until 07/15/10, seven (7) days later. Interview on 07/27/10 at 5:00 PM, 07/28/10 at 5:00 PM and 07/30/10 at 10:30 AM with Licensed Practical Nurse (LPN) #2/Nurse Manager on the D Wing where Resident #3 resided, revealed the resident should have had an abdominal assessment after three days with no bowel movement documented. She further stated a laxative prn (as needed) should have been administered. Continued interview revealed the Nurse Managers ran a clinical report from the computer every morning which showed which residents had not had a bowel movement in three days and reviewed the list. The list was then	F 309		

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F 309	Continued From page 17 given to the nurses administering medications. She further stated, the weekend supervisor ran the reports on the weekends. LPN #2 was unsure why the bowel protocol had not been followed for this resident. Interview on 07/28/10 at 4:15 PM and 07/29/10 at 2:00 PM with the Director of Nursing revealed there was no written Bowel Protocol. She stated, the unit nurses were to check the bowel record on the computer to ensure the Certified Nursing Assistants (CNAs) had imputed the information each shift and the Nurse Managers were to run a critical alert report daily to give to the nurses which would include the Bowel Movement Record. She further stated the Unit Managers were to audit the BM Records to ensure the resident had a bowel movement at least every three days. Continued interview revealed "We have a protocol, we are just not following it". 3. Review of Resident #12's medical record revealed diagnoses which included Alzheimer's Disease, Senile Dementia, and Constipation. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/25/10 revealed the resident was severely impaired for cognitive skills in decision making, was unable to ambulate, and was totally incontinent of bowel and bladder Review of Resident #12's Bowl Movement (BM) Record revealed no bowel movement was recorded from 06/11/10 to 06/17/10, six (6) days later; from 06/17/10 to 06/24/10, seven (7) days later; and, 06/28/10 to 07/05/10, seven (7) days later. Review of the June 2010 Physician's Orders revealed orders for Senna S two tablets every	F 309		

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F 309	Continued From page 18 night for constipation, and Miralax 17 Grams with water every morning for constipation. Further review of the Physician's Orders revealed there was no as needed (prn) orders for a laxative. Interview on 07/30/10 at 7:35 AM with LPN #4, who was assigned to the resident on the C wing in which Resident #12 resided, revealed she assessed and checked bowel sounds starting on the 2nd day when there was no bowel movement for this resident due to the resident's bowels being sluggish. However, she did not record her assessment. She stated she was unsure why the resident had gone long periods without a bowel movement, and stated there could be a problem with the Certified Nursing Assistants (CNAs) inputing the bowel movements into the computer. 4. Review of Resident #14's medical record revealed the resident was admitted with diagnoses which included Dementia, Diabetes Mellitus, and Generalized Weakness. Review of the June 2010 and July 2010 Physician's Orders revealed an order for Senna-S 2 tablets every night. Review of the Bowel Movement (BM) Record revealed no documented evidence of a BM for six (6) days, from 06/03/10 until 06/09/10; for five (5) days, from 06/09/10 until 06/14/10; and, no documented evidence of a BM for eight (8) days, from 06/14/10 until 06/22/10. Further review revealed no documented evidence of a BM for seventeen (17) days, from 06/24/10 through 07/11/10; for six (6) days, 07/11/10 through 07/17/10; and, no documented evidence of a BM for ten (10) days, from 07/17/10 through 07/27/10.	F 309		

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F 309	Continued From page 19 Interview on 07/30/10 at 8:35 AM with Licensed Practical Nurse (LPN) #2/ AB Unit Manager, revealed nurses were required to check bowel movements in the computer every shift. She stated the nurses would then administer a laxative if the resident went three days without a bowel movement, unless a laxative was contraindicated. Further interview revealed, the Certified Nursing Assistants (CNA's) were to document all bowel movements each shift.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the residents' environment remained as free of accident hazards as possible. Observations revealed chemicals and potentially hazardous equipment in the beauty salon were accessible to residents. The findings include: 1. Observation on 07/28/10 at 8:15 AM revealed an unlocked resident bathroom on the B Hall that had one (1) gallon of lotion sitting on top of a cabinet and another gallon, ¾ full sitting on the shower wall ledge. Further observation revealed	F 323		

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F 323	Continued From page 20 shampoo and body wash sitting on the shower wall ledge without a top. Review of the Material Safety Data Sheet (MSDA) for these chemicals revealed the physician or poison control center should be called if swallowed. Observation on 07/28/10 at 9:15 AM on the A Hall, revealed room three (3) had a loose towel bar in the bathroom. Interview with the Maintenance Supervisor on 07/28/10 at 9:15 AM indicated towel bar was loose. 2. Observation on 07/28/10 at 12:45 PM of the beauty salon revealed the door was left unlocked and unattended. Further observation revealed a pair of scissors and a hot curling iron were accessible on the counter. Interview with the beautician on 07/28/10 at 12:45 PM revealed she had taken a resident to the dining room and returned to the salon immediately after. The beautician further stated the salon door should had been locked so no one could enter and touch items in salon. 3. Observation on 07/27/10 at 10:20 AM revealed the door leading from the resident occupied area of the facility down the corridor to the kitchen was unlocked. The kitchen door was also unlocked. Upon entering the kitchen it was determined that the chemical room door was unlocked. Observation of the chemical room revealed a shelve which contained multiple chemicals including three (3), two (2) gallon containers of bleach which were labeled as being corrosive. The shelve also contained six (6) bottles of dish	F 323	F323 Shower Room and Loose Towel Bar The combination lock on the shower room and the loose towel bar was changed immediately upon learning that it was not working properly. 7/28/10. All shower rooms were checked to ensure that the locks were working properly. All towel bars were checked to ensure that they were securely fastened to the wall. 7/28/10. All staff will be in-serviced by Staff Development Coordinator or designee to immediately report when the shower room lock is not working properly and to report if a towel bar is not securely fastened to the wall. 9/13/10. Maintenance Director or designee will audit the shower room lock 1 x day for 3 months. Maintenance Director or designee will audit the security of towel bars to the wall 1 x week x 3 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10	9/13/10

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F 323	Continued From page 21 washing liquid, pot and pan detergent which was labeled as an eye irritant and a case of mild foam hand sanitizer. One (1) container of hand sanitizer was sitting on top of a case which was labeled "vapors may cause fire". Additional observations revealed a metal shelve was unlocked and contained multiple chemicals including stainless steel cleaner and polish labeled as being harmful if swallowed. The metal shelve also included six (6) hour wick chafing fuel which labeled "with acute inhalation effects of unconsciousness and death". Interview with the Director of Food and Nutrition Services on 07/30/10 at 7:25 AM revealed residents were not allowed beyond the first door from the resident occupied area of the facility. However, during interview with the Director of Food and Nutrition Services, she stated the door was never locked to the kitchen and she could lock the chemical door, but that was not practical because housekeeping uses some of the items stored in the metal cabinet and the dietary staff enter the chemical room consistently. Observation on 07/30/10 at 3:00 PM revealed the door to the chemical room in the kitchen remained unlocked as well as both the door into the kitchen and the door from the resident occupied area of the facility. Interview with Dietary Aide #14 on 07/30/10 at 3:15 PM revealed residents have entered from the resident occupied area of the facility into the employee only area. He further states that the residents are redirected because they are not supposed to be in this hallway.	F 323	Beauty Salon The beauty salon will remain locked at all times. All salon operators and staff will be re-educated by Administrator or designee on the need to keep the salon door securely locked during their absence. Activity Director or designee will audit whether the salon operators are complying with the policy 2 x weekly for 3 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10. Chemical Room Door in Kitchen The chemical room will remain locked at all times. A combination lock will be installed 8/24/10. The dietary staff was in-serviced on 8/18/10. The Dietary Supervisor or designee will conduct audits daily for 30 days and weekly x 2 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10.	9/13/10 9/13/10
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 22 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. During initial tour resident water mugs were noted to be stored wet. The meat slicer was noted to be stored covered with food particles remaining on the blade surface. The freezer was observed to have ice build-up on the floor and boxes of food items were noted to have ice build up. A ceiling vent was dirty. Food temperatures were not monitored in all serving areas and cold food was not held at the appropriate temperature. The findings include: 1. Observation on 07/27/10 at 10:45 AM revealed twelve (12) resident water mugs stored wet with one (1) having a lid on it and three (3) having straws also stored inside of them wet. Interview with the Dietary Supervisor on 07/27/10 at 10:45 AM revealed the water mugs were clean mugs that would be passed to residents as nurses brought in dirty water mugs to be cleaned. The Dietary Supervisor further indicated that the	F 371	F371 Water Mugs The water mugs will be washed, rinsed and sanitized daily, utilizing the dishwashing machine. They will be air dried before they are stored on the shelves. This process was immediately followed after learning that the water mugs were stored wet. 7/27/10. The Dietary Staff were in-serviced on the policy on 8/18/10. The Dietary Supervisor or designee will conduct audits daily for 30 days and weekly x 2 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10. Meat Slicer The meat slicer will be washed, rinsed and sanitized per manufacturing cleaning instructions after each use. The meat slicer will then be air dried and covered with a plastic bag labeled for food only. The cooks were in-serviced on 8/18/10. The Dietary Supervisor or designee will conduct audits daily for 30 days and weekly x 2 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10.	9/13/10 9/13/10

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	185268	A. BUILDING _____ B. WING _____	C 07/30/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN	3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 clean mugs should not be stored wet and sent the water mugs back to the dishwasher. 2. Observation on 07/27/10 at 10:52 AM revealed the walk-in freezer had ice build-up on five (5) areas of the floor that were approximately baseball size. There was ice build-up noted on two (2) boxes of individual serve ice cream. The box of chocolate individual serve ice cream was opened with approximately half of the individual containers were gone, and the ice build-up was approximately one (one) quarter of an inch thick. There was also ice build-up on one (1) box of great shake vanilla drinks. Ice build-up was noted to be present on the fans of the condenser unit and on the pipe entering the unit from the back of the freezer. Interview with the Director of Food and Nutrition Services on 07/27/10 revealed that she would check the items for freezer burn before using and if they showed signs of freezer burn they would be discarded. She further indicated the freezer was old and that the staff were consistently having to chip ice away from the floors and the pipe leading into the freezer condensing unit. Interview with the Director of Maintenance on 07/29/10 revealed that the facility had a contract for the maintenance of the freezer and the contract holder performs maintenance yearly and as needed. He further indicated because of the high humidity the contract worker stated there was nothing that could be done to stop the ice from forming. The Director of Maintenance stated the cooling unit for the freezer was five (5) years old. 3. Observation on 07/27/10 at 11:05 AM revealed	F 371	Ice Build-up Freezer Curtains were ordered on 8/18/10 to reduce the possibility of ice build-up in the freezer. They will be installed as soon as possible but no later than 9/13/10. The dietary staff was in-serviced to look for ice build-up in the freezer and to ensure that it is kept clean at all times. 8/18/10. The Dietary Supervisor or designee will conduct ongoing weekly audits for ice build up in freezers and cleanliness. If ice build-up is present, the Dietary Supervisor or designee will remove affected food from that area to discard or to prevent freezer burn. They will also inform the Maintenance Supervisor or designee by filling out a work order request. Maintenance Supervisor will de-ice the freezer and/or take other appropriate measures to address the issue. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10.	9/13/10

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F 371	Continued From page 24 the meat slicer was stored under a protective plastic covering with hardened particles noted on the blade and the base of the slicer. Interview with the Director of Food and Nutrition Services on 07/27/10 at 11:05 AM revealed the meat slicer was cleaned after each use. She further indicated that the hardened particles appeared to be some type of meat particles which suggested that someone had not clean it well after the last use. Review of information for staff located in the kitchen area near the meat slicer labeled Equipment Cleaning revealed directions on cleaning the meat slicer. Per the directions titled, "How to Clean the Slicer", the slicer must be washed, rinsed and sanitized after each use. The directions for the slicer were updated 4/2009. 4. Observation on 07/27/10 at 5:00 PM revealed the Cook taking temperatures of the dinner time meal. The temperatures of the turkey sandwiches was fifty-five (55) degrees Farenheit and the pureed turkey for the turkey sandwiches was sixty (60) degrees Farenheit. The Cook did not return these food items to the cooler, tray line proceeded and the items were served to residents. Observation on 07/27/10 at 5:30 PM revealed the tray line was broken down and food items were transported to the dining room for service to residents in this area. Observation of the reassembled tray line in the dining area at 5:50 PM revealed that no temperatures were taken before the tray line began. Interview with the Director of Food and Nutrition	F 371	Vents Kitchen vents will be cleaned monthly by the maintenance department. If cleaning is needed prior to the monthly cleaning, dietary staff will clean the vents. Cleaning of kitchen vents have been added to the monthly cleaning schedule for maintenance. 8/17/10. The Maintenance Staff were in-serviced on cleaning vents on 8/17/10. Dietary staff was in-serviced on 8/18/10. The Dietary and Maintenance Supervisor and/or designee will conduct audits monthly x 3 months to ensure that vents are cleaned as scheduled. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10. Food Temperatures Food Temperature will be taken three times per meal to ensure that all foods are safe to be served. Food Temperatures will be taken during the cooking process, and before food is served from the tray line. Tray line temperatures will be recorded. Foods that are not at the correct temperature will be further heated or chilled to achieve the correct temperatures. Once foods are transported to the dining room and placed on the dining room steam table, food temperatures will be taken and recorded again.	9/13/10 9/13/10

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F 371	Continued From page 25 Services on 07/29/10 at 5:35 PM revealed the items were too warm for service because they were intended to be cold serve food items, the should have been held at forty one (41) degrees or less. Further observation on 07/29/10 at 5:45 PM revealed the tray line was reassembled in the dining area without temperatures being documented before serving began. Interview with the Director of Food and Nutrition Services on 07/30/10 at 7:30 AM revealed that temperatures were not always taken and never recorded in the dining area before beginning tray line for residents in that area. She further indicated that it depended on the staff member if the temperatures were taken before tray line began in the dining area. Interview with Cook # 15 revealed she checked and document temperatures in the kitchen, however, she did not check or document temperatures before beginning tray line in the dining room. 5. Observation on 07/29/10 at 5:00 PM revealed a vent in the ceiling of the kitchen located approximately ten (10) feet from the tray line was covered with a blackish brown substance. Interview with the Cook on 07/29/10 at 5:00 PM revealed the substance looked like mold or dust. She further stated it could be either one. Interview with the Director of Food and Nutrition Services on 07/29/10 revealed the substance appeared to be dust covering the vent. She further indicated it was the responsibility of the	F 371	Food Temperatures (con't) Dietary staff was in-serviced on this procedure on 8/18/10. The Dietary Supervisor and or designee will audit this process daily x 1 month and weekly x2 months to ensure that this process is adhered to. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10.	9/13/10

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F 371	Continued From page 26 Maintenance Department to clean the vents. Interview with the Director of Maintenance on 07/29/10 revealed the substance appears to be dust. He further stated that he probably should clean it and that he tried to clean when he was able to get into the kitchen. He indicated that he had requested the dietary staff clean the vent and perhaps they were not able to.	F 371	F465 Resident Dining Rooms The facility will contact Johnson University to inquire as to what products will work best to eliminate the possibility of sticky floors. All resident dining rooms will be mopped three times a day using the regimen suggested by Johnson University. All Housekeeping staff will be in-serviced Environmental Services Director or designee on the suggestions given by Johnson University. 9/13/10. The Housekeeping Supervisor will audit the dining room floors 2 x daily for 1 month, then 2 x weekly for 2 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10.	9/13/10
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The findings include: 1. Observation of two (2) resident dining room floors revealed the floors were sticky throughout the survey from 07/27/10 through 07/30/10. Interview on 07/29/10 at 2:50 PM with the Supervisor of Housekeeping/ Laundry, revealed the housekeepers were expected to do "floor work" which consisted of cleaning shower rooms, nurses stations, offices, and the learning room everyday. She stated the laundry person mopped the dining rooms on Tuesday, Wednesday and	F 465	Odor in B3 Carpet was removed from B3 on 8/2/10. Carpet has been removed from all resident rooms. 9/13/10. All staff will be in-serviced Staff Development Coordinator or designee to empty resident urinals timely and to clean up any bodily fluids that may contaminate the floor. 9/13/10. Housekeeping Supervisor or designee will audit the smell of that room daily x 30 days, then weekly x 2 months. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10	9/13/10

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F 465	Continued From page 27 Thursday evenings, and the kitchen employees mopped the dining rooms Friday through Monday evenings. Interview on 07/29/10 at 2:50 PM with the supervisor revealed the floors in the dining rooms were mopped three (3) times. First with a cleaner then with a sanitizer and last with hot water. She did not know why the floors were sticky in dining rooms. However she did state she was in the process of training a housekeeper to pick up on floor work in the morning hours of 7:00 AM until 12:00 noon. 2. Observation of room 3B throughout the survey from 07/27/10 through 07/30/10, revealed the room had a strong odor and the carpet was soiled. Further interview on 07/28/10 at 2:50 PM with the Supervisor of Housekeeping/ Laundry, revealed the floor technicians were to check the rooms daily for stains on the carpet and to shampoo the carpets as needed. She stated, there was no schedule for shampooing the residents' room carpets. Continued interview revealed she had never had it brought to her attention that room 3B had an odor. On 07/28/10 at 8:15 AM, the supervisor was in room 3B and confirmed the room did have an odor. Review of the facility's Resident Room Routine Cleaning Policy revealed it was recommended that a full mopping be done at least twice a week on Monday and Friday preferably, with spot cleaning done through the week. If resident rooms were carpeted, a minimum of bi-weekly vacuuming was recommended.	F 465	Oxygen Concentrators All residents with oxygen concentrators were cleaned on 7/28/10. Administrator will contact Holdaway and have them provide documentation to ensure that they clean all oxygen concentrator filters as per the contract in the future. Staff Development Coordinator or designee will in-service Nursing staff by 9/13/10 to ask for documentation from Holdaway before they leave the building to ensure documentation of the services provided. 9/13/10. DON or designee will audit this process weekly x 3 month. The results of the audits will be reported to the Quality Assurance Committee for review and further recommendation. 9/13/10.	9/13/10

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F 465	Continued From page 28 3. Observation on 07/28/10 at 9:20 AM on A Hall room three (3) bed A revealed a oxygen concentrator filter was dirty. Interview with the Administrator on 07/28/10 at 9:40 AM revealed the facility had a contract with an oxygen supplier to check and maintain the concentrator to the manufacturer's specifications which included the cleaning of all filters weekly. However the facility was unable to provide evidence that the oxygen filters were cleaned prior to 07/28/10.	F 465	F514 The facility will monitor meal percentages and fluid intake on resident 4. The DNS or designee will monitor daily meal percentages and fluid intake x 3 months to ensure the information has been documented in the hand-held. CNAs will be re-educated by the Staff Development Coordinator or designee on the importance of documenting resident's food and fluid intake and to report to the Charge nurse or Unit Coordinator if a resident's pattern of intake declines. 9/13/10. CNAs will report to their Charge nurse at the end of the shift to ensure required meal percentages and fluid consumption has been documented. The DNS or designee will monitor food and fluid consumption daily x 3 months to ensure the information has been documented. A QA audit will be performed on 10% of residents on each unit to ensure food and fluid consumption has been documented. The audit will be performed monthly for 6 months. The data will be presented at the monthly QA meeting for further evaluation and recommendations. 9/13/10.	9/13/10
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure clinical records were maintained in accordance with accepted professional standards and practices for one (1) of nineteen (19) sampled residents (Resident #4).	F 514		

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F 514	Continued From page 29 The findings include: Review of Resident #4's medical record revealed diagnoses which included Dementia, Diverticulitis, Irritable Colon, and Diabetes Mellitus. Review of the Significant Change Minimum Data Set (MDS) Assessment dated 06/24/10, and the Quarterly MDS Assessment dated 03/09/10, revealed the facility assessed the resident as having moderate impairment in cognitive skills for decision making, and requiring supervision and limited assistance with eating. Review of the Resident Assessment Protocol Summary (RAPS), dated 06/23/10 revealed the resident received a mechanical soft diet due to difficulties with chewing and swallowing. Review of the Plan of Care dated 03/03/10 revealed the resident had a history of Dysphagia, required a mechanically altered diet, left 25% uneaten at most meals, and had difficulty chewing. The goal included: will tolerate diet consistency, and will stabilize weight within five (5) pounds of current weight 193.4. Review of the Food/Fluid Consumption Sheet for 05/10 revealed no evidence the facility monitored the resident's food and fluid intake on 05/21/10 for the noon and evening meal, 05/24/10 for the evening meal, and 05/29/10 for the noon and evening meal. Interview on 07/28/10 at 3:30 PM and 07/30/10 at 11:15 AM with Licensed Practical Nurse (LPN) #2, who was the Nurse Manager on the AB unit in which Resident #4 resided in May 2010, revealed she checked the computer periodically to see if the Certified Nursing Assistants (CNAs) had	F 514		

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F 514	Continued From page 30 imputed the food and fluid intake into the computer; however, she did not check to see how much a resident was eating and drinking. She further stated the staff nurses were to check the resident's food and fluid intake every shift and document if the intake was poor. She further stated she needed to be more diligent about looking at the documentation. Interview on 07/28/10 at 4:40 PM with the Director of Nursing, revealed the nurses should monitor the food and fluid intake every meal and if there was a problem the Physician would be notified. She further stated the Certified Nursing Assistants (CNAs) imputed the meal and fluid intake into the computer and the Nurse Managers needed to print it out for review. Further interview revealed the Food and Fluid Intakes had been computerized for less than a year, and there was some problems noted with imputing the information.	F 514		

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 07/29/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "D".	K 000	**Plan of Correction** Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure a combustible canopy located at the front of the facility was sprinkler-protected, as required. The findings include: Observation on 07/29/10 at 12:35 PM, with the Maintenance Director, revealed a canopy of combustible construction (wood) which was approximately 6 feet by 14 feet in size, located at the conference room entrance of the facility, which was noted not to be sprinkler-protected. Interview on 07/29/10 at 12:35 PM, with the Maintenance Director, revealed that the facility was not aware of the canopy not having the required sprinkler protection. Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steven M. Mitchell | TITLE: Administrator | (X6) DATE: 8/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 1 Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012	K012 Installation of a sprinkler head in the canopy will occur no later than 9/13/10. Pro Fire Extinguishment will conduct an inspection of our building to ensure that we do not have any additional areas that require sprinklers. All maintenance staff was in-serviced on the need for a sprinkler in a combustible canopy over 4ft by the Environmental Services Director on 7/29/10. The Environmental Services Director or designee will test the newly installed sprinkler to ensure that it is working properly; and will test it annually thereafter. The Environmental Services Director or designee will report his findings to the QA committee.	9/13/10